Other Insurance Reporting Requirements

Claim Adjustment Reason Code: 22- this care may be covered by another payer per coordination of benefits

Policy: Medicaid Provider Manual (MPM) Chapter "Coordination of Benefits"

Federal regulations require that all identifiable financial resources be utilized prior to expenditure of Medicaid funds for most health care services provided to Medicaid beneficiaries. Medicaid is considered the payer of last resort. Billing Medicaid prior to exhausting other insurance resources may be considered fraud under the Medicaid False Claim Act if the provider is aware that the beneficiary had other insurance coverage for the services rendered Providers must secure other insurance adjudication response(s) which must include Claim Adjustment Reason Codes (CARCs) prior to billing Medicaid. Denials do not need to be obtained in cases where the parameters of the carrier would never cover a specific service (e.g., a dental carrier would never cover a vision service, etc.). In cases where the provider renders a service and the carrier indicates it does not cover that specific service, the provider needs only to bill the carrier once for the service and keep a copy of the denial in the beneficiary's file. When billing electronically, no attachment is necessary, as all required data must be included in the electronic submission

When billing a secondary or tertiary claim to Medicaid it is important to report the correct claim filing indicator for the payer on the claim. Reporting an incorrect claim filing indicator can result in claims being unnecessarily suspended, denied, voided, or paid incorrectly.

The major categories of other insurance are:

- Commercial health insurance carriers (i.e., managed care carriers [MCC], preferred provider organizations [PPO], point of service organizations [POS], health maintenance organizations [HMO], long-term care [LTC] insurance policies), traditional indemnity policies, and military/veteran insurance (i.e., TRICARE and the Civilian Health and Medical Program of the Department of Veterans Affairs [CHAMPVA]).Auto Insurance (accident, no-fault)
- Workers' Disability Compensation
- Court-Ordered Medical Support
- General Liability Insurance
- Medicare

Examples:

Payer	CHAMPS Claim Filing Indicator
BC BS Federal Employee Program	BL- BC/BS
Traditional Medicare	Medicare A or Medicare B
Medicare Advantage Plans	Commercial, HMO or Medicare B (Preferred)
Priority Health Plan	Commercial

MDHHS assigns coverage type codes which indicate the type of coverage a policy entails.

Examples:

Coverage Type Code	Description
RX	Only Pharmacy
MD	Medical Dental- Medical and Dental Coverage Only
DO	Only Dental

Notes:

- When using Direct Data Entry to enter a new claim or adjustment the Payer ID, Group Number, Policy Number, and Claim Filing Indicator information must match what is shown in the TPL files within CHAMPS eligibility subsystem.
- If submitting a claim electronically the claim filing indicator must match what is shown in the TPL files within CHAMPS eligibility subsystem. It is not currently required for the Payer ID, Group and Policy Number to match the beneficiary TPL files when submitting electronically.
- If the TPL files are incorrect then the online DCH 0078- Request to add/change/update other insurance needs to be completed (exceptions: BCBS, BCN, Medicare, and McLaren)
- Paper claims are not recommended as they are not reliable, they impose an administrative burden to both the provider and to the SOM, and may lead to incorrect payments, denials and ultimately will delay reimbursement.